LETTERS TO THE EDITOR

Letters intended for publication should be a maximum of 500 words, 10 references, and one table or figure, and should be sent to the editor at the address given on the inside front cover. Those responding to articles or correspondence published in the journal should be received within six weeks of publication.

Smoking among Buddhist monks in Phnom Penh, Cambodia

EDITOR,—According to existing studies, Buddhist monks can have an impact on smoking cessation in a given population.[1 2] It is because of their influence that Buddhist monks in Phnom Penh, Cambodia were selected for a study of their knowledge, attitudes, and practices concerning tobacco, with the long term objective of developing ways of enlisting their support in tobacco control efforts in Cambodia.

The 30 cluster survey method was employed, wherein all of the temples in the city were listed and, according to the number of monks residing at them, 30 sites were randomly selected for interviewing from seven to 11 monks each for a total of 318 interviews. Questions were designed to reflect the potentially sensitive issue of smoking among religious practitioners. There were no cases of interview refusal.

When all 318 respondents were asked, "Do you want to quit smoking?" 44% gave some type of answer other than "not applicable": 37% said "yes", 3% "no", and 4% "not sure". Also, when all respondents were asked, "Why do you want/not want to quit?" a total of 44% gave some reason. Finally, when asked, "What do you do with the tobacco gift packages you receive?" 44% of the 318 respondents mentioned that they smoke the gift tobacco themselves. These figures lead us to believe that the prevalence of current smokers among Buddhist monks is 44%. In comparison, smoking prevalence among the general male population in Phnom Penh is almost 65% (1994) and among Buddhist monks in Thailand 56% (1990).[3 4]

Of the influences to start smoking 26% of respondents said that an individual friend was the main influence to start smoking; 18% responded group pressure from friends or other monks; 21% complimentary cigarettes; 12% work/stress; 8% father's influence; 3% advertising; and 12% other reasons. As can be seen, these two influences alone—individual friends and group pressure—were responsible for almost half of all influences to start smoking.

When asked what they thought the teachings of Buddha have to say about smoking, 91% of respondents said the teachings of Buddha do not say anything; but when asked if there should be a Buddhist law that recommends monks do not smoke, 71% replied "yes". When asked if the government should require warning messages on all tobacco advertising, 94% agreed; 96% agreed that the government should ban all tobacco advertising.

About one third (34%) of all respondents thought that people should not offer cigarettes to monks, while an equivalent percentage (38%) thought people should. Another approximately one third was not sure. These figures can be partially explained by a question in the survey that asked what monks did with the tobacco gift packages. Over 50% "give" the cigarettes away. More commonly, the cigarettes are sold or bartered for extra income, but it would not be appropriate, according to Buddhist principles, to admit this.

Direct assistance for smoking cessation programmes is urgently needed: 84% of smokers want to quit; if a program was available to help people stop smoking, 95% of smokers said they would attend; 86% of all respondents would be willing to teach people about the effects of smoking.

The pattern of responses indicates that, even though the teachings of Buddha do not say anything about smoking directly, there is a stigma tied to smoking that inhibits many monks from admitting their smoking habits directly. The large majority of monks feel that smoking is not an appropriate practice and that there should be a Buddhist law that recommends they do not smoke.

Most monks, however, have little understanding of the specific detrimental effects smoking has on them, as well as the effects of second hand smoke. Health education is needed to raise such awareness, as are cessation programmes to help bring about desired behaviour changes.

The small scale of this research makes it difficult to generalise conclusions for monks throughout the country. However, it does provide useful insights into some trends in tobacco use among monks in Cambodia and highlights a number of important issues for further research. Most importantly, this study reveals the potential that exists for successful cooperation with monks in tobacco control efforts in Cambodia.

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MARSHALL T S SMITH
TAKUSEI UMENAI
Department of Health Policy and Planning, Graduate School of International Health, Faculty of Medicine, University of Tokyo, Tokyo, Japan
Smith: marshall@m.u-tokyo.ac.jp

1 Anon. Influence of religious leaders on smoking cessation in a rural population—Thailand, 1991. *MMWR Morb Mortal Wkly Rep* 1993; **42**:367–9.
2 Swaddiwudhipong W, Chaovakiratipong C, *et al*. A Thai monk: an agent for smoking reduction in a rural population. *Int J Epidemiol* 1993;**22**:660–5.
3 Smith M, Umenai T, Radford C. Prevalence of smoking in Cambodia. *J Epidemiol* 1998;**8**:85–9.
4 Chitanondh H. *Tobacco use: an update—April 1991*. Bangkok, Thailand: Ministry of Public Health, Office for Tobacco Consumption Control, National Committee for Control of Tobacco Use, 1991.

Effect of smokefree bar law on bar revenues in California

EDITOR,—In 1998 a California state smokefree workplace law requiring that bars be smoke free went into effect.[1 2] Both before passage of this law and shortly after it went into effect, the tobacco industry and its allies predicted that it would hurt the bar business. To test the hypothesis that smoke free bar legislation harms the bar business, we obtained total revenues from eating and drinking establishments licenced to serve all forms of alcohol ("bar revenues") from the tax authorities in California (fig 1). We conducted an analysis of these data following a similar approach to earlier analyses of the effects of smokefree restaurant and bar ordinances on communities.[3–4]

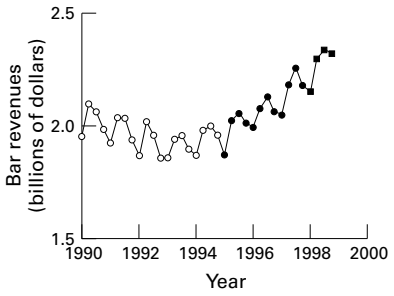

Figure 1 Total revenues from eating and drinking establishments with full liquor licences in California before a state smokefree workplace law went into effect (open circles), after restaurant provisions went into effect (solid circles), and when bars were required to be smokefree (solid squares). Data from quarterly reports of the California State Board of Equalization.

Briefly, we divided bar revenues by total retail sales to account for underlying economic conditions and inflation and conducted a multiple linear regression analysis with time, calendar quarter, a dummy variable to indicate whether the restaurant provisions the law were in force (0 before 1 January 1995, and 1 afterwards), and another dummy variable to indicate if the bar provisions were in force (0 before 1 January 1998, and 1 afterwards). We also examined the fraction of all "eating and drinking establishment" revenues that were going to those with liquor licenses to see if there was any shift in the mix of business associated with either the restaurant or bar provisions of the state smoke free workplace law. (Note that these bar revenues include both revenues of restaurants that include bars as well as free standing bars.[4])

There was no significant effect of the restaurant provisions of the law on bar revenues as a fraction of total retail sales (coefficient of dummy variable −0.01 (0.04)%, p = 0.811); there was a small but significant positive change in bar revenues as a fraction of retail sales associated with the bar provisions going into effect (coefficient 0.09 (0.04)%, p = 0.029). Implementation of the smokefree restaurant provisions was associated with an increase in the fraction of all eating and drinking establishment revenues that went to establishments with liquor licenses (0.54 (0.27)%, p = 0.054), and a larger increase following implementation of the smokefree bar provisions (0.73 (0.25)%, p = 0.007).

As with claims of adverse effects on the restaurant[5] and tourist[6] industries, these data further discredit tobacco industry claims that smokefree bar laws are bad for the bar business. Quite the contrary, these laws appear to be good for business.

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STANTON A GLANTZ
Institute for Health Policy Studies, Cardiovascular Research Institute, Box 0130, University of California, San Francisco, CA 94143-1030, USA;
glantz@medicine.ucsf.edu